

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

15148

PLACE OF DEATH  
County Shannon  
Township Jackson  
or  
Village Reefer  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 637 File No. 2  
Primary Registration District No. 6084 Registered No. \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Francis Banks

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married  
(If write the word)  
DATE OF BIRTH Aug. 24, 1852  
(Month) (Day) (Year)  
AGE 73 yrs. 9 mos. 15 ds. If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE Ind. Shannon Co  
(City or town, State or foreign country) Missouri

PARENTS  
NAME OF FATHER Andy Summers  
BIRTHPLACE OF FATHER Ind. Shannon Co  
(City or town, State or foreign country) Missouri  
MAIDEN NAME OF MOTHER Adeline S. Rogers  
BIRTHPLACE OF MOTHER Ind. Shannon Co  
(City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) A. F. Banks  
(ADDRESS) Lincoln, Mo.

Filed Apr. 20, 1926 Mrs. Clem Dooley  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 18, 1926  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 16, 1926, to Apr. 18, 1926, that I last saw her alive on Mar. 16, 1926, and that death occurred, on the date stated above, at 11:30 P. m.  
The CAUSE OF DEATH\* was as follows:

Influenza - General  
Sensibility  
(Duration) 11 yrs. 10 mos. 30 ds.

Contributory (SECONDARY) (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) T. A. Batty M. D.  
Apr. 20, 1926 (Address) Center Grove, Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Akers Cemetery DATE OF BURIAL Apr. 20, 1926  
UNDERTAKER J ADDRESS \_\_\_\_\_

## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_  
or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City \_\_\_\_\_

(NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_

Ward) \_\_\_\_\_

If death occurred in a hospital or institution, give its name and number of street and number.

## FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)

DATE OF BIRTH	(Month) _____	(Day) _____	(Year) _____
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AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?
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OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____
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BIRTHPLACE (City or town, State or foreign country)
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NAME OF FATHER
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BIRTHPLACE OF FATHER (City or town, State or foreign country)
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MAIDEN NAME OF MOTHER
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BIRTHPLACE OF MOTHER (City or town, State or foreign country)
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THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_\_

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## DATE OF DEATH

\_\_\_\_\_, 191\_\_\_\_\_, (Month) \_\_\_\_\_, 191\_\_\_\_\_, (Day) \_\_\_\_\_, 191\_\_\_\_\_, (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

## Contributory

(SECONDARY)

(Signed) \_\_\_\_\_

\_\_\_\_\_, 191\_\_\_\_\_ (Address) \_\_\_\_\_

M. D.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVAGENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

191\_\_\_\_\_

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
County Shannon Registration District No. 637 File No. 2  
Township Jackson Primary Registration District No. 6084 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
2. FULL NAME Francis Banks  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER Andy Summers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind  
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Edeline Boyd

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind  
(STATE OR COUNTRY) Mo.

14. INFORMANT \_\_\_\_\_  
(Address) \_\_\_\_\_

15. FILED Aug 20 1926 Mrs. Helen Dooley  
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 18 1926

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,

that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) J. A. Baltz, M. D.

, 19 (Address) Edinburg, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER none ADDRESS \_\_\_\_\_

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

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